GEORGIA DEPARTMENT OF COMMUNITY HEALTH

TOPICAL ANTI-ACNE MEDICATIONS

PREFERRED	Avita, Azelex, Clindamycin (gel, lotion, solution), Duac, Erythromycin (gel, solution), Erythromycin-Benzoyl Peroxide, Metronidazole gel, Tazorac (cream, gel), Tretinoin microsphere gel, Ziana
NON-PREFERRED	Acanya, Aczone gel, Adapalene cream/gel, Atralin, BenzaClin, Benzamycin Pak, Benzoyl Peroxide 5%/Clindamycin 1% gel (generic Benzaclin), Clindagel, Clindamycin Phosphate Swab, Clindamycin foam, Clindamycin 1.2%/Benzoyl Peroxide 5% gel (generic Duac), Clindacin PAC Kit, Differin, Epiduo, EryPads, Erythromycin Swab, Evoclin, Finacea, Finacea Plus Kit, Metrogel Pump, Metronidazole (cream, lotion), Noritate, Retin-A Micro, Retin-A Micro Pump, Rosadan kit (metronidazole 0.75% cream, OTC skin cleanser), Tretinoin (cream, gel), Tretinoin Microsphere Pump, Veltin

LENGTH OF AUTHORIZATION: 1 Year

NOTE: *Atralin gel, Azelex, Avita, Differin, Tretinoin cream/gel, and Ziana will be subject to the DCH clinical PA criteria for members ages 21 years or older. Tazorac will be subject to the DCH clinical PA criteria for members 30 years or older in order to verify diagnosis. If generic adapalene is approved, the PA will be issued for brand-name Differin. If Evoclin is approved, the PA will be issued for generic clindamycin 1% foam.*

PA CRITERIA:

For Avita, Azelex, Tretinoin Micro

- Approvable for members with a diagnosis of acne vulgaris

For Atralin

- Approvable for members with a diagnosis of acne vulgaris who have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or intolerable side effects with two preferred products

For Adapalene, Differin, EpiDuo

- Approvable for members with a diagnosis of acne vulgaris who have experienced ineffectiveness, allergies, contraindications, drug-drug interactions, or intolerable side effects with two preferred products, one of which must be Avita

For Tazorac

- Approvable for members with a diagnosis of acne vulgaris who have failed therapy with either Avita or Retin-A Micro

OR

- Approvable for plaque psoriasis in members who have failed therapy with a generic topical corticosteroid

For Tretinoin

- Approvable for members with a diagnosis of acne vulgaris who have failed therapy with Avita or Tretinoin Micro Gel AND Azelex.

For Veltin

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred products (clindamycin 1% gel and tretinoin 0.025% gel or Ziana) are not appropriate for the member with acne vulgaris.

For Acanya, BenzaClin (brand or generic)

- Approvable for members with a diagnosis of acne vulgaris who have failed therapy with two preferred topical antibiotic products for acne, one of which must be Duac

For Aczone

- Approvable for members with a diagnosis of acne vulgaris who have failed therapy with two preferred topical antibiotic products for acne

For Clindagel or Clindamycin Phosphate Swab

- Approvable for members with a diagnosis of acne vulgaris who have failed therapy with two preferred topical antibiotic products for acne, one of which must be clindamycin.

For Clindamycin 1.2%/Benzoyl Peroxide 5% gel (generic Duac)

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product (Duac, which does not require PA) is not appropriate for the member.

For EryPads or Erythromycin Swabs

- Approvable for members with a diagnosis of acne vulgaris who have failed therapy with two preferred topical antibiotic products for acne, one of which must be erythromycin gel or solution.

For Evoclin (brand or generic) or Clindacin PAC Kit

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product (clindamycin 1% gel, lotion, or solution) is not appropriate for the member.

For Finacea, Metrogel Pump, Metronidazole cream/lotion, Noritate, or Rosadan Kit

- Approvable for members with a diagnosis of acne rosacea

AND

- Member must have a history of allergic reactions, intolerable side effects, contraindications, drug-drug interactions, or ineffectiveness to metronidazole gel.

For Finacea Plus Kit

- Prescriber must submit a written letter of medical necessity stating the reasons the non-preferred product (Finacea gel, which also requires PA) is not appropriate for the member.

For Retin-A Micro Gel, Retin-A Micro Pump, Tretinoin Micro Pump

- Prescriber must submit a written letter of medical necessity stating the reasons the preferred product, generic tretinoin micro gel in tube (not pump), is not appropriate for the member..

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.

- The Prior Authorization process may be initiated by calling **Catamaran at 1-866-525-5827.**

PA and Appeal Process:

- For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on "prior approval process".

Quantity Level Limitations:

- For online access to the current Quantity Level Limits please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.